Removal of middle initial "C." from name of deceased: affidavit of Mr. C.B.Bishop, informant, filmed 8-28-45 G97.L.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

08428

CERTIFICATE OF DEATH

Reg. Dist. No. 351

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Worcester (INCORPORATE LIMITS)
City or town: Snow Hill
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 70 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Snow Hill
(If outside city or town limits, write RURAL and give nearest town)
Street No. or (If rural, give LOCATION)
(Note: deceased was registered voter in Worcester county, however spent winters at 12 E. 25 St. Balto. Md. - information from informant by phone 8-28-45 LL)
2.(a) If veteran, name war

3.(a) FULL NAME: Sallie C. Bishop

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 16 - 1875

8. AGE:

Years	Months	Days	If less than one day
70	6	2	hrs. min.

9. Birthplace: Snow Hill Worcester Md
(Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER
12. Name: Dr. George W. Bishop
13. Birthplace: Maryland

MOTHER
14. Maiden name: Ellen E. Pinkney
15. Birthplace: Maryland

16. Informant: Mr. Chas. C. Bishop
Address: 1703 Bolton St. Baltimore Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 20 45 (month) (day) (year)
Cemetery or crematory: Evergreen
Location: Snow Hill, Md

18. Funeral director: Pearne & Dennis
Address: Snow Hill, Md

19. 8/8 19 45 (Date rec'd by registrar) LeRoy Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 17 1945, at 5 45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8/2/45 19 to 8/17/45 19 and that I last saw her alive on 8/12/45 19

Immediate cause of death	DURATION
Rheumatic Heart Disease	30 yr
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Paul Owen M.D.
M. D. or other
Address: Salisbury, Md. Date signed 8/17/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

08429

Reg. Diat. No. 351

WITHIN CORPORATE LIMITS OF

1. PLACE OF DEATH:
County Worcester
City or town Snow Hill
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 57 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Worcester
City or town Snow Hill
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war No

3.(a) FULL NAME Susie Brittingham

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Oct. 10 - 1887

8. AGE: Years	Months	Days	If less than one day
57	10	6	hrs. min.

9. Birthplace Snow Hill Worcester Md
(Town, county, and state)
10. Usual occupation Home
11. Industry or business
FATHER 12. Name Benjamin Brittingham
13. Birthplace Maryland
MOTHER 14. Maiden name Mitchell
15. Birthplace "
16. Informant Mrs Cuntie Schoolfield
Address Snow Hill, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 19 45 (month) (day) (year)
Cemetery or crematory Baptist
Location Snow Hill Md
18. Funeral director Pearne & Dennis
Address Snow Hill Md
19. 8/18/45 (Date rec'd by registrar) LeRoy Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 16 19 45 at 5-4 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 22 19 44 to Aug 16 19 45 and that I last saw her alive on Aug 16 19 45

	DURATION
Immediate cause of death: Cerebral Vascular Accident	3 Hours
Due to: Hypertensive Cardio-Vascular renal disease	10 yrs.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Robert L. LaMar M.D.
M. D. or other
Address Snow Hill Date signed 8/16/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (830)

08430

CERTIFICATE OF DEATH

★ Reg. Dist. No. 357

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Worcester
City or town: Snow Hill (If outside city or town limits, write RURAL and give nearest town)
WITHIN CORPORATE LIMITS OF
How long in above place of death? 88 Years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Snow Hill (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war: No

3.(a) FULL NAME: Priscilla P. Cottingham

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 31 - 1857

8. AGE: Years: 88 | Months | Days | If less than one day: hrs. min.

9. Birthplace: Snow Hill Worcester Md (Town, county, and state)
10. Usual occupation: None
11. Industry or business:
12. FATHER — Name: Peter D. Cottingham
13. Birthplace: Maryland
MOTHER — 14. Maiden name: Elizabeth Parker
15. Birthplace: Maryland
16. Informant: Mrs. Wm. R. Powell
Address: Snow Hill, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 3 / 45 (month) (day) (year)
Cemetery or crematory: Wheatcroft Methodist
Location: Snow Hill, Md
18. Funeral director: Adams & Dennis
Address: Snow Hill Md
19. 8/3/45 (Date rec'd by registrar) LeRoy Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 1 1945, at 11 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 16 1944 to Aug 1 1945 and that I last saw h.. alive on Aug 1 1945

Immediate cause of death	DURATION
Cerebral Vascular Accident	1 wk
Due to: Arteriosclerosis & senility	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Robert L. LeMar M.D. M. D. or other
Address: Snow Hill Date signed: 8/3/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46-E

CERTIFICATE OF DEATH

08431

Reg. Dist. No. 351

1. PLACE OF DEATH:
County: Worcester
City or town: Girdletree Rural #1
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Girdletree Rural #1
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3.(a) FULL NAME: Ardella Johnson

3.(b) Social Security Number: None

4. Sex: Female
5. Color or race: Colored
6.(a) Single, married, widowed, or divorced: Widowed
6.(b) Name of husband or wife: Jewell Johnson
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): March 9 - 1878

8. AGE: Years: 67 Months: 7 Days: 5 If less than one day: ... hrs. ... min.

9. Birthplace: Snow Hill Worcester Md (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Own Home
FATHER 12. Name: Isaac Bratten
13. Birthplace: Maryland
MOTHER 14. Maiden name: Mitchell
15. Birthplace: Va
16. Informant: Mr Wilmer J. Waters
Address: Girdletree, Md Rural #1
17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 18 45 (month) (day) (year)
Cemetery or crematory: M.E. Wesley
Location: Snow Hill Md
18. Funeral director: Hearne & Dennis
Address: Snow Hill, Md
19. 8/18 19 45 R. Ray Smith Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 14 19 45 at 10 15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1 19 45, to August 14 19 45
and that I last saw h... alive on August 14 19 45

	DURATION
Immediate cause of death: Abdominal Malignancy - Original Site & type unknown Primary	1 yr.
Due to: Carcinoma of uterus.	
Due to: Duration 3 Dep. months. C.W.&R.	
Other conditions: Hypertension & hypertensive Cardio-Vascular renal disease	unknown

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results: ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE: Paul Cohen M.D. M. D. or other
Address: Snow Hill Date signed: 8/18/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (183)

CERTIFICATE OF DEATH

08432

Reg. Dist. No. 350

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Worcester

City or town: Pocomoke City

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 60 years.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Worcester

City or town: Pocomoke City

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Bettie Rue Johnson

3.(b) Social Security Number 1[illegible]-05-[illegible]55

4. Sex: Female

5. Color or race: Colored

6.(a) Single, married, widowed, or divorced: Widowed

6.(b) Name of husband or wife: Jacob Johnson

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 68 years.

8. AGE: Years — Months — Days — If less than one day ..... hrs. ..... min.

9. Birthplace: Mappsville Accomac Co. Va.

(Town, county, and state)

10. Usual occupation: House work

11. Industry or business

FATHER

12. Name: Isaac Warrington

13. Birthplace: Va

MOTHER

14. Maiden name: Hannah Savage

15. Birthplace: Va.

16. Informant: James Johnson

Address: Pocomoke City Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 22 1945 (month) (day) (year)

Cemetery or crematory: Hall's Hill Cemetery

Location: Rural Pocomoke Md.

18. Funeral director: Marguette Watson

Address: Pocomoke road.

19. Aug 22 1945 (Date rec'd by registrar) Anne E. White Registrar

1880

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 17 1945 - instantaneous at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
accidentally drowned	
Due to: Falling in gravel pit	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of Aug 17 45

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: John L. Riley Dep Med Exam M. D. or other

Address: Berlin Md Date signed Aug 18 45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73rd)

CERTIFICATE OF DEATH

08433

Reg. Dist. No. 355

1. PLACE OF DEATH:

County: Worcester

City or town: Ocean City

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 weeks

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: [illegible] County: D.C.

City or town: Washington D.C.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 5108 9th St N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME John Richard Perry

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	married

6.(b) Name of husband or wife: Lorrie Perry

6.(c) If alive, give age: 35 years

7. Birth date of deceased (mo., day, yr.): April 17 1905

8. AGE: Years: 40 | Months: 3 | Days: 27 | If less than one day: hrs. min.

9. Birthplace: Bloomington Ind

(Town, county, and state)

10. Usual occupation: Draft man

11. Industry or business: Navy Dept

FATHER 12. Name: Herman Perry

FATHER 13. Birthplace: Bloomington Ind

MOTHER 14. Maiden name: Pearl May

MOTHER 15. Birthplace: Bloomington Ind.

16. Informant: Mrs Richard Perry

Address: Washington D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-14-45 (month) (day) (year)

Cemetery or crematory: Rosehill Cemetery

Location: Bloomington Ind.

18. Funeral director: Anna A. Burbage

Address: Berlin, Md.

19. 8-15 1945 (Date rec'd by registrar) Helen F. Hammond Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 11 1945, at 4:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from [illegible] 19[illegible], to [illegible] 19[illegible]

and that I last saw h[illegible] alive on [illegible] 19[illegible]

Immediate cause of death	DURATION
Myocardial degeneration of heart	Few minutes
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John L. Riley Dep Med Exam M. D. or other

Address Brown Hill Md. Date signed Aug 11 45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08434

CERTIFICATE OF DEATH

★ Reg. Dist. No. 350

1. PLACE OF DEATH:
County: Worcester
City or town: Pocomoke
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 years
Hospital, Institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Pocomoke
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Rural
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Susie Elizabeth Pilchard

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: —
6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): April 21, 1915

8. AGE: Years: 30 | Months: 3 | Days: 26 | If less than one day: ... hrs. ... min.

9. Birthplace: Pocomoke, Worcester, Md.
(Town, county, and state)

10. Usual occupation: Student nurse

11. Industry or business: —

FATHER
12. Name: Charles Pilchard
13. Birthplace: md

MOTHER
14. Maiden name: Susan Justice
15. Birthplace: md

16. Informant: Walton Pilchard
Address: Pocomoke City Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 19-1945 (month) (day) (year)
Cemetery or crematory: Hall's Hill Baptist
Location: Pocomoke City Md

19. Funeral director: Margarette L. Walston
Address: Pocomoke City Md

19. Aug 24 1945 (Date rec'd by registrar) Anne E. White Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 17 1945, at 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1935 to Aug 16 1945 and that I last saw her alive on Aug 16th 1945

Immediate cause of death: C. T. B. of Lungs — DURATION: 10 yrs.
Due to: —
Due to: —
Other conditions: —
(Include pregnancy within 3 months of death)

Major findings of operation: —
Date of op.: —
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of: —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): —
Means of injury: — Injured at work?

23. SIGNATURE: R. E. Parsons M. D. or other
Address: Pocomoke City Date signed 8/23/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 35

CERTIFICATE OF DEATH

Reg. Dist. No. 3-55 (18435)

1. PLACE OF DEATH:
County Worcester
City or town Ocean City
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 weeks
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Balto City
City or town Baltimore, Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 937 N. Patterson Park Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Margaret Dolan Sheridan

3.(b) Social Security Number ✓

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fem.	W	married

6.(b) Name of husband or wife Jarrett M. Sheridan
6.(c) If alive, give age 55 years
7. Birth date of deceased (mo., day, yr.) Oct 28 1890

8. AGE: Years	Months	Days	If less than one day
54	9	7	..... hrs. ..... min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name Henry J. Dolan
13. Birthplace Baltimore Md
MOTHER 14. Maiden name Elizabeth Kortz
15. Birthplace Baltimore Md
16. Informant Jarrett M. Sheridan
Address Baltimore, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 8-1945 (month) (day) (year)
Cemetery or crematory Baltimore Cemetery
Location Baltimore City Md.
18. Funeral director Margaretta Dolan
Address Roanoke City Md.
19. 8-6 1945 (Date rec'd by registrar) Helen F. Howard Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 5 1945, at 3 a. M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Cerebral hemorrhage	10 min
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE John L. Riley Dep. Med Exam M. D. or other
Address Glen Hill Md Date signed Aug 5 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (14-a)

CERTIFICATE OF DEATH

08436

Reg. Diat. No. 353

1. PLACE OF DEATH:
County: Worcester
City or town: Bishopville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: ~~Ohio~~ Md. County: Worcester
City or town: Bishopville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Minnie Ann Tubbs

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug 11, 1945

8. AGE: Years | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Maryland
(Town, county, and State)

10. Usual occupation

11. Industry or business Farming & Chickens

FATHER
12. Name Bill Tubbs
13. Birthplace Maryland

MOTHER
14. Maiden name Elizabeth Taylor
15. Birthplace Maryland

16. Informant Elizabeth Tubbs
Address Selbyville R.D. 2

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 13 1945 (month) (day) (year)
Cemetery or crematory St Martins Meth Church
Location Bishopville, Md.

18. Funeral director M. Pasta Watson
Address Selbyville, Del.

19. Aug 12 1945 (Date rec'd by registrar) Mackey Burgess Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 12 1945 at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 11 1945 to Aug 12 1945 and that I last saw h.er alive on Aug 12 1945

	DURATION
Immediate cause of death: Atelectasis	24 hrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE Theicold, M.D.
M. D. or other
Address Berlin Md. Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1)

CERTIFICATE OF DEATH

08437

Reg. Dist. No. 350

1. PLACE OF DEATH:

County Worcester

City or town Pocomoke city

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Worcester

City or town Pocomoke city

(If outside city or town limits, write RURAL and give nearest town)

Street No. Clarke ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Nora L. Tilghman Wilson

3.(b) Social Security Number ✓

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Widowed

6.(b) Name of husband or wife John Lloyd Wilson

6.(c) If alive, give age ✓ years

7. Birth date of deceased (mo., day, yr.) January 16, 1867

8. AGE: Years	Months	Days	If less than one day
78	6	29	...hrs. ...min.

9. Birthplace Pocomoke, Worcester, Md. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER — 12. Name George Tilghman

13. Birthplace Md

MOTHER — 14. Maiden name Sallie Bratten Jones

15. Birthplace Md

16. Informant Mrs. Nora Boston

Address Pocomoke city, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 17, 1945 (month) (day) (year)

Cemetery or crematory Salem M. E.

Location Pocomoke city, Md.

18. Funeral director Marguerite H. Watson

Address Pocomoke city, Md.

19. Aug. 17 1945 (Date rec'd by registrar) Anne E. White Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 15 1945, at 9 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Aug 15 1945, to Aug 15 1945

and that I last saw h... alive on Aug 13 1945

Immediate cause of death	DURATION
Paralysis	5 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE E. E. Tilghman M. D. or other

Address [illegible] Date signed 8-17-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 2nd

CERTIFICATE OF DEATH

★ 08438

Reg. Dist. No. 350

(M) (1)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH

County Worcester

City or town Pocomoke city

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Worcester

City or town Pocomoke City

(If outside city or town limits, write RURAL and give nearest town)

Street No. Cedar

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Edward Washington Young Sr

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife Mary Elizabeth Young

6.(c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) April 15, 1872

8. AGE: Years	Months	Days	If less than one day
73	4	12	....hrs. ....min.

9. Birthplace Manokin, Somerset, md (Town, county, and state)

10. Usual occupation Waterman + Mechanic

11. Industry or business

FATHER 12. Name Samuel James Young

13. Birthplace md

MOTHER 14. Maiden name Mary Elizabeth Lawrence

15. Birthplace Del

16. Informant Edward W. Young Jr

Address Pocomoke city, md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 30, 1945 (month) (day) (year)

Cemetery or crematory Hall's Hill

Location Pocomoke city

18. Funeral director Marquette H. Gratton

Address Pocomoke city, md.

19. Aug 29 1945 (Date rec'd by registrar) Alice E. White Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 27 1945, at 11 30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1945, to Aug 27 1945

and that I last saw h...alive on Aug 26 1945

Immediate cause of death	DURATION
Sudden collapse	two
Due to Chronic endocarditis	5 yr
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE F. M. Wilson M. D.

Address Pocomoke City Date signed 8-29-45

VS A15